UNMET NEED FOR FAMILY PLANNING: A COMPARISON OF COMMUNITY-LEVEL STUDIES IN GUATEMALA, INDIA AND ZAMBIA (PRELIMINARY FINDINGS)

Nancy V. Yinger
International Center for Research on Women
Washington, DC, USA

Linda Asturias de Barrios
Estudio 1360, S.A.
Guatemala City, Guatemala

Hema Viswanathan
The Institute for Social and Rural Research
New Delhi, India

Andrew Mushingeh
University of Zambia
Lusaka, Zambia

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INTRODUCTION

The concept of unmet need for family planning has been identified in recent years as a woman-centered way to define one of the targets population for family planning programs (in addition to current users whose service needs must continue to be met). An average of 20 percent of women in developing countries are defined to have an unmet need for family planning, i.e. they say they would prefer to control their fertility, yet they are not using any form of family planning (Robey, et al, 1996). It is estimated that if programs were to successfully address this apparent behavioral contradiction, women's own needs would be met, and in many countries fertility would reach replacement level (Sinding, et al. 1994). Yet the concept of unmet need has been criticized -- it is a definitional construct calculated from large-scale surveys, primarily the Demographic and Health Surveys (DHS), not a direct measure of women's self-defined need for family planning services. In addition, it leaves out key groups of women who have clear unmet needs for services -- the unmarried, those using ineffective methods or effective methods ineffectively, and those dissatisfied with their current methods (Germain and Dixon-Mueller, 1992). It is also possible that the current definition captures women who do not belong in the category, sub-fecund women for example or married women whose husbands are not living at home.

An improved measure of unmet need would not only accurately indicate the proportion of women who fall into the category but would also contribute to a greater understanding of its underlying causes. Women classified as having an unmet need for family planning are clearly not a homogeneous group, and an improved measure would help distinguish among differing degrees of motivation to avoid a pregnancy. The current measure is based on simple "yes" or "no" responses to a series of questions about fertility preferences and contraceptive use and is therefore unable to capture these differences. In addition, the causes of unmet need are identified in the DHS through a single open-ended question where women are asked to state the reason why they do not currently use contraception. A single question is not sufficient to determine the relative importance of the different factors that influence women's contraceptive behavior. It is likely that an individual's need to space or limit pregnancies is determined by a complex interaction of service-related, sociocultural, and economic factors (Bongaarts and Bruce, 1995; Stover and Heaton, 1995).

To address these concerns, ICRW has conducted[1] a collaborative in-depth research program using a combination of quantitative and qualitative approaches. This paper presents preliminary qualitative findings[2] from this research program concerning two issues: 1) the definition of unmet need, and 2) its underlying causes. We also present some preliminary policy recommendations.

DESCRIPTION OF THE RESEARCH TEAMS AND SITES

[1] This research program is funded by USAID, the Offices of Population and Women in Development.
[2] When the abstract for this paper was submitted last October, the qualitative findings from all three studies were scheduled to be completed. Unfortunately, due to the inevitable delays in the data collection process, the research team in Zambia is still completing data collection from one of its sites.

The research being presented here is a collaborative effort between ICRW and research teams in three countries:

- In Guatemala, ICRW is collaborating with Linda Asturias de Barrios and her colleagues from Estudio 1360, a social science research institution, to conduct a study in a peri-urban community of Guatemala City.

- In India, ICRW is working with Hema Viswanathan and her staff at the Social and Rural Research Institute of New Delhi, to carry out community-level studies in rural and urban sites in Sitapur and Agra districts of Uttar Pradesh.

- In Zambia, ICRW's collaborator is Andrew Mushingeh, an anthropologist at the University of Zambia. He is studying two compounds in Lusaka (one lower and one middle socioeconomic status) and two in Mansa, the capitol of a northern province.

Table 1 provides a snapshot of the research design and sites. The sample sizes for each site are relatively small. The goal was to take an in-depth look at a few communities to get a better understanding of unmet need from the perspective of people who would be "assigned" to the unmet group by the DHS definition. We also collected data from people whose need for family planning services has been met, as a basis of comparison, and from the partners and others who influence family planning decision-making, e.g. mothers-in-law in India. We also wanted to explore modifications to the definition, particularly those suggested by the critical literature.

The data collection process in each site had two steps. First a screening survey, based on a random sample, was carried out to identify women with unmet need. Then a purposive sample that included predetermined categories (met and unmet need, age, residence, etc.) was drawn and interviewed in depth. The interviews basically took a life-cycle approach to trace women's knowledge of and behavior concerning major reproductive health issues, including use of family planning. While the country studies all followed this same basic process, each study also includes particular areas of interest to the individual teams. In Guatemala, the team used the screening survey to explore different ways of defining and measuring unmet need quantitatively; in India, a follow-up survey is currently in the field to quantify several key causes of unmet need that were identified during the in-depth interviews; and in Zambia the research team designed their purposive sample for the in-depth interviews to include a significant proportion of unmarried women, and attempted to interview a partner or "significant other" for each of the women interviewed. [3]

TABLE 1: OVERVIEW OF THE RESEARCH SITES AND SAMPLE SIZES

[3] The complete country studies, as well as reports-in-brief and a synthesis paper, will be available over the course of the summer of 1997. For more information or copies please contact Nancy Yinger at ICRW (Nancy@ICRW.org).

COUNTRY	NUMBER OF SITES	SAMPLE FOR SCREENING SURVEY	SAMPLE FOR IN-DEPTH INTERVIEWS	DATES
GUATEMALA	1 peri-urban neighborhood in Guatemala City	275	68 sexually-active women 10 men	Survey 12/1995 Interviews 2-4/1996
INDIA: THE STATE OF UTTAR PRADESH	Agra District 6 rural villages 2 urban wards	 108 45	35 married women 15 men 10 mothers-in-law (per district)	Survey 8/96 Interviews 9-10/1996 (both districts) Follow-up survey 3/97 (in Sitapur only)
	Sitapur District 6 rural villages 2 urban wards	179 59	35 married women 15 men 10 mothers-in-law	
ZAMBIA	2 compounds in Lusaka	206	50 sexually-active women and 35 of their partners	Survey 8/96 Interviews 12/96
	2 compounds in Mansa	103	20 sexually-active women and their partners	Survey 2/97 Interviews 3/97

DEFINITION OF UNMET NEED

The concept of unmet need originated in the knowledge, attitude, and practice (KAP) studies of the 1950s and 1960s, when the term "KAP-gap" was used to describe married women who said they wanted no more children yet were not using any method of contraception. Over the years the concept and its measurement have been considerably refined. Currently, the most common measure of unmet need, developed by the Demographic and Health Surveys (DHS) Project, includes in-union, fecund women who say they would prefer not to have any more children or to postpone their next birth for at least two years but who are not using any method of contraception. It also includes pregnant or amenorrheic women whose current or latest pregnancy was unwanted or mistimed and who were not using a contraceptive method at the time of conception (Westoff and Bankole, 1995). In sum, it refers to married women who are

not practicing family planning despite an expressed preference for spacing or limiting births.

The literature on unmet need criticizes two aspects of this definition:

1. The definition has been criticized for being too narrow, for excluding certain groups of women who clearly need (better) family planning services -- women who are dissatisfied with the method they are currently using, women who are using effective methods incorrectly, and women who are using highly ineffective methods (all of the above include use of methods or dissatisfaction by partners as well). The literature also suggests including unmarried women. This is essentially a data issue, since much of the original DHS data from which the definition was developed was only collected on married women. Now, almost everyone would agree that all sexually-active women should be included in the definition and analysis, if reliable data were available. This implies adding women not-in-union and subtracting married women who are not sexually active -- whose spouses are away for an extended period of time or who no longer engage in sexual relations. The challenge here is to be able to accurately identify who is sexually active, since single women, who are often adolescents, may not provide accurate responses to questions on this topic.

2. The current definition assumes a degree of homogeneity among the unmet need group by only dividing women into spacers and limiters when in fact there are many factors making it a heterogeneous group, for example, the degree of motivation to practice family planning.

This research presented here suggests a rationale for revising the definition along the lines suggested by the critical literature. Referring to Figure 1 (attached after the references), which presents a continuum of risk of unintended pregnancy, the DHS definition draws a clear line between users and non-users, while the critics suggest including several categories of users. The preliminary findings from the ICRW studies suggest that the more inclusive definition is appropriate because if we are really going to understand women's unmet need for services, we should move beyond measuring just family planning behavior (or lack thereof) to the potential results of that behavior, i.e. unintended pregnancy. Since unintended pregnancies result from method failure, incorrect use of methods, use of highly ineffective methods (folk methods[4]), as well as non-use of methods, a more women-centered definition of unmet need would include those cases.

[4] The study in Guatemala suggests that we should be careful when we think about folk methods and not automatically assign women who use them to an unmet need category. There are women who feel they are successfully using folk methods to achieve their family planning objectives. A case in Guatemala was a woman who had been using "parsley water" for five years to successfully avoid a pregnancy. She felt no need of "better" family planning services. In the Guatemala study, a woman using a folk method was classified as having unmet need if there was clear evidence of the failure of the method (i.e. an unintended pregnancy) yet the woman continued to use the method.

In addition, the majority of women with unmet need (defined in the conventional DHS way) in most countries have used a method at some time in the past. They overcame the initial barriers to use (probably the hardest to overcome), but still face other barriers to continuing or resuming use (discussed below). Thus, we submit that there may be less difference between these nonusers and users than the conventional DHS definition of unmet need implies. Our data suggest that the non-users and users with moderate risk are more alike than the users with moderate risk and the users with very low risk. For example, women who are dissatisfied with their method today are likely to discontinue and become non-users tomorrow; whereas women who are currently pregnant or amenorrheic and not using any method but who used successfully in the past (i.e. they discontinued to have a planned pregnancy), could easily become tomorrow's users.[5]

We recognize that it is much more complicated to measure unmet need to avoid unwanted births than unmet need as it is currently measured. One of the reasons the current DHS definition is widely used is that it is conceptually compact, and that makes it relatively easy to construct internationally comparable results. That has its value but may not ultimately provide the best data to guide the development of programs tailored to women's needs.

With respect to adding more heterogeneity into the definition, it is clearly needed and is interwoven with the multiple causes of unmet need. Among both limiters and spacers, there are women who say they intend to use a method in the future and women who say they do not (these data can be drawn from DHS). While intentions are far from perfect predictors of subsequent behavior, they give some guidance on the kinds of programs that would be needed (Curtis and Westoff, 1996).

Future intention to contracept is one way to "cut the pie;" there could be other ways to slice it as well. This research highlights two key points about adding more categories to the definition: 1) the same categories might not be appropriate for all countries and 2) there is a series of issues that program planners might need to address before they determine the appropriate categories for their own country. Why do women who would prefer to control their fertility not do so effectively:

- because they are terrified of the rumors they have heard about modern methods (and thus use no method or choose a folk method with which they are familiar) ;
- because their husbands are opposed (or they think their husbands are opposed);
- because they have very little control over any aspect of their lives, much less their reproductive lives;

[5] In Guatemala, quantitative analysis, presented elsewhere, indicates that unmet need would go up by 10 points if dissatisfied users were included in the definition.

- because they have had a bad experience in the past with side effects;
- because they believe certain family planning methods are at odds with common sexual practices;
- because they are quite ambivalent about future childbearing, for example they think if they have another child it might "cement" a currently shaky relationship; and/or
- because they are still amenorrheic after a recent birth and do not think they need to contracept yet?

Each of these causes would result in different program interventions. Thus any definition of unmet need is less useful than it could be if it only serves to identify the number of women in need of better services, without helping to identify what kind of services those women need and how to reach them. Across the bottom of Figure 1 are some ideas about the services that women at different points on the continuum might need. The evidence from the studies in Guatemala, India and Zambia, however, makes clear that a focus only on service-delivery issues will not "solve" unmet need.

The study in Guatemala divided women with unmet need into four categories: never used, erratic users, discontinuers, and those who experienced a method failure. For each of these groups, the researchers analyzed the reasons for non-use.[6] It is important to note that women gave between two and five reasons for not using a method. Table 2 shows that overall, gender subordination -- the man is against the use of contraception, or the woman is waiting for the man's approval or for him to choose the method -- dissatisfaction, reproductive status and fear of side effects are the most common reasons. However, within each of the categories, there are differences. For those who have never used, fear of side effects was cited most, while among those who have experienced a method failure, gender subordination and dissatisfaction are more common. The erratic users cited a wider range reasons and on average gave slightly more reasons for non-use. These data support the suggestion that it is important to identify the appropriate sub-categories in order to best design program interventions.

[6] This study included some women who are using methods but are dissatisfied or are using methods incorrectly in their definition of unmet need . The data cited here refer just to women who were not using any method at the time they were interviewed.

TABLE 2: THE NUMBER OF WOMEN GIVING PARTICULAR REASONS FOR NON-USE OF FAMILY PLANNING AMONG WOMEN WITH UNMET NEED IN A PERI-URBAN COMMUNITY OF GUATEMALA CITY, 1995

CATEGORY REASON FOR NON-USE	NEVER USED (N = 9)	ERRATIC USER (N = 5)	EXPERIENCED METHOD FAILURE (N = 7)	GAVE UP (N = 7)	TOTAL (N = 28)
LACK OF MONEY				1	1
LACK OF TIME		1			1
HEALTH	1				1
RELIGION	1	1			2
PROCRASTINATION	2	1			3
NOT SEXUALLY ACTIVE	2		3	1	6
GENDER SUBORDINATION	3	2	4	3	12
DISSATISFACTION		3	4	3	10
REPRODUCTIVE STATUS	4	2	2	3	11
FEAR OF SIDE EFFECTS	5	2	2	4	13
AVERAGE NUMBER OF REASONS	2	2.4	2.1	2.1	2.1

One final point with regard to the definition. This research suggests that it may be time to reconsider including the wantedness of the **current or just completed** pregnancy for pregnant and amenorrheic women instead of their future childbearing intentions. While pregnant and amenorrheic women may not be at high risk of pregnancy at the time of the survey, they will soon be, and some amenorrheic women may already be at significant risk if they are more than six months post-partum and/or not using exclusive breastfeeding for their newborn. It is the wantedness of future children that will have more influence on their intention to contracept, and it is the strength of that motivation that will determine whether they act on their intentions.[7]

[7] On a practical note, all the teams working on this research program found it counterintuitive that for pregnant and amenorrheic women the current or just completed pregnancy would be considered while for all other women it would be their future childbearing intentions. For that matter, they also found it counterintuitive that women with unintended pregnancies resulting from contraceptive failure should not be included in unmet need.

THE CAUSES OF UNMET NEED

The need for a definition with more sub-categories is linked directly to the causes of unmet need. The dramatic statistic that 20 percent of women in the developing world (or 100 million women) can be categorized as having an unmet need for family planning is often worded as , "the proportion of married women who would like to space or limit births but *do not have access* to family planning." (The Washington Post, 1997). [emphasis added] The evidence from the most recent round of DHS (which included for the first time questions on reasons for non-use of family planning), other in-depth studies, and the research presented here is that access, per se, is not one of the major causes of unmet need.

Bongaarts and Bruce (1995) use DHS data from 13 countries to show that lack of knowledge about family planning and health concerns are the primary reasons for nonuse of contraception among women with unmet need (cited by 25 percent and 20 percent of women respectively). Lack of access was cited by only 4 percent, along with religion, opposition to family planning and cost (3 percent). In a broad sense, lack of knowledge is a lack of effective access, but the way programs to address unmet need would be designed differs radically if they are addressing access defined as the number of service delivery points or defined as enhancing people's effective knowledge of family planning methods including the benefits and side-effects of each to help them choose the approach that is best for them.

In-depth studies, highlighted on Figure 2, indicate that the main reasons for unmet need include women's perceptions of their husbands' negative attitudes toward family planning and a real fear of the side effects of modern methods. Again access per se does not appear to be one of the main causes of unmet need.

FIGURE 2: CAUSES OF UNMET NEED: EVIDENCE FROM ASIA

Philippines (Casterline, et al, 1995)

- Husband's fertility preferences
- Husband's perception of health side effects
- Woman's view on the acceptability of contracepting
- Woman's perception of her risk of conceiving
- Woman's perception of health side effects

Nepal (Stash, 1995)

- A cluster of health-related concerns: fear of side effects; economic ramifications of recuperation; perceived increased nutritional demands on men and women
- Social costs: husband's objections to fertility limitation; desire for additional sons
- Psychological costs: costs of undertaking innovative behavior

Guatemala

The in-depth interviews in Guatemala City weave a rich tapestry on the causes of unmet need, pulling the treads directly from the perspective of women who would like to avoid a pregnancy but are not using any method of family planning to do so. The discussion that follows is the textual data from which Table 2 above was constructed.

Fear of Side Effects: The women's fear of side effects results both from lack of information and from their own understanding of how the body works, influenced by traditional medical beliefs. The following case illustrates a 31 year old Ladino woman's fears about injections. She used to use injections, but gave them up for fear of severe hemorrhaging the blood she believes accumulates in her body during the months she does not menstruate.

> *After the second girl was born, both a friend and her employer told the woman that she should go to APROFAM. Her period came back a year and eight months after the girl was born. APROFAM gave the woman an injection, because she was breastfeeding. Her period stopped on the second month. She used the injection for four months and then gave it up, because she hadn't had her period. She was afraid that she would experience a severe hemorrhage when her period finally came.* (Paraphrased, 51)

The next case is a 29 year old Ladino woman, mother of five, who has never used contraceptive methods and does not trust them.

> *All I know about contraceptive methods is what I have heard in television --channels 3 and 7. I have never used pills, injections or the copper T. The method that I really do not trust, and would not like to use, is that which looks like a balloon, the one which the man wears.... The husband of a women who lived here as a tenant wore that thing and had sex with his wife; but the balloon exploded inside her, and she felt a lot of discomfort. She went to the doctor, who said that he found nothing wrong; however, eight days latter the woman urinated a piece of latex. She urinated that, and got pregnant anyhow, and her child was born with a piece of latex in his eye. The balloon exploded inside her..* (30)

Reproductive Status: Women also mentioned, as reasons for not using any method of family planning, that they were waiting for the post-partum period of sexual abstinence to end (usually 40 days), or for post-partum amenorrhea to conclude. For most of the women interviewed -- both users and non-users of family planning -- post-partum amenorrhea is an indication that they are temporarily "safe". Because breastfeeding is a common practice among the women in the study, they may be amenorrheic for over a year, and feeling "safe" in this condition, they wait for their first

period before looking for a contraceptive method. However, the women are at risk of pregnancy while they wait, because they are not necessarily exclusively breastfeeding their newborns.

> *My husband wanted me to use birth control, but I was not taking or using anything. I had been told that one doesn't get pregnant while breastfeeding; but I did. I got pregnant with my second child when my first child was 9 months old; and pregnant with my third child as I was breastfeeding my second child.* (224)

Gender subordination: Gender subordination includes reasons related to decisions or attitudes on the part of the woman's husband. One is the husband's explicit opposition to family planning, which may even take a violent turn:

> *I was more aware, so I went to get pills from the health center, without his knowledge. He knew nothing, but found where I had hidden the pills, and burnt them. He said that I was taking them because I had a lover. But I was doing it to prevent hardship. I could not continue taking the pills because he beat me. He beat me more because he said I had a lover.* (264)

In other cases, a woman is not using any method because her husband has not decided whether she should use them, or has not selected the particular method she should use. A 36 year old woman has six living children, of the nine children to which she gave birth. Both she and her husband want to space future pregnancies, but she is waiting for him to take the initiative and decide which method they will use. Gender subordination has been a pattern is the couple's life. When the man asked for the woman's hand in marriage, he literally asked her whether "she wanted to be under his power". She thinks that if her husband did not want her to use a contraceptive method, she "would just have as many children as would come, because she would feel embarrassed about doing something behind his back" (paraphrased notes from the interview, 36).

Dissatisfaction: The woman's or the couple's dissatisfaction with a method may lead them to abandon it. Such dissatisfaction may be due to incorrect use of the method or fear about its side effects. If no attempt is made to look for a substitute method, the woman may go from being a user to being a nonuser, thus increasing her risk of an unintended pregnancy. The following quote from a 33 year old woman illustrates this situation:

> *I felt all right when I was using the T. But one is supposed to have a check-up every year, and I waited four years. I went to be checked because I was getting very thin. I hadn't gone before, because I thought that it was going to hurt a lot. My neighbor told me that the T could*

become embedded in the flesh, and I should have it checked. I went for the check up, but the T had become embedded in my flesh, and they pulled down on my uterus. My head was pounding. I was dizzy and with nausea, and stayed sick for 8 days. At APROFAM they told me that I should go back, to see what I wanted to do -- whether to get injections or take pills. But, just thinking of all that pain kept me from going back; I preferred to have another child. We did nothing, and I had another two children. (275)

Not sexually Active: Infrequent sex was also reported as a reason for not using contraceptive methods. This reason must be understood within the context of cultural and reproductive beliefs held by the community. The risk of becoming pregnant is often associated with frequent sex. It is believed that if the woman only has sex every once in a while, there is little chance that she will become pregnant. Also, if the woman's husband works away from home for several weeks, or even months, at a time, this idea is reinforced by the cultural expectation that the woman should be faithful. A woman who uses a birth control method under such circumstances may be viewed with suspicion by her husband. A 30 year old Ladino woman illustrates this situation:

I have been without anything for two months, because my husband is not here. As I see it, a woman uses birth control when she is having sex. When she is without a husband, she shouldn't be using anything, because she is not having sex at all. (50)

Procrastination: "I have let time go by" is one of the answers given by the women to explain why they are not using birth control. These are women who have decided to space or prevent future pregnancies, but have not made the transition to doing something about it. Some of them planned to use a contraceptive method after giving birth, or after their post-partum amenorrhea, but have let time go by without taking action. The following is an example of procrastination, combined with lack of money and time:

We haven't bought anything, and I haven't gone to be treated, because it is an expense, and we don't have the money. I thought of going to a health center nearby, but I don't have the time. He wants me to go; but the health center only sees patients in the morning, so I cannot go in the afternoon. I must remember to do it. I haven't yet set a day aside to do it; maybe I will go a week from now. (177)

Multiple reasons for not using a method: As indicated above, most of the women interviewed gave two or more reasons for not using birth control. Here is an example from a 26 year old woman:

I have made the decision to use a birth control method. Last Monday, I spoke with my partner about going together to find out if there were any methods he could use; but he did not want to go. I asked him whether he wanted me to do something to prevent another pregnancy. He said yes; and I asked him: Which method should I use? He said that he didn't know, and that I should get whatever agrees with me. We both realize that we must use birth control, but he left up to me the decision of what to use. Birth control is against religious teachings. My mother does not want me to use contraceptives. I fear God's punishment, so first of all I ask for His forgiveness; but I think that there is no reason I should bring more children into this world, since they will only suffer.

My mother did not get pregnant until she stopped breastfeeding. I think that breastfeeding is a form of birth control, but it doesn't work for all women. I am hoping that it is working for me. I haven't got an injection since March, and the effect of the last one was up in June. There have been three months, and I haven't got pregnant. If I had the chance, I would use birth control. I asked my husband to go with me but he didn't want to. I am planning on going by myself, because I am concerned that I will get pregnant, and my child is still very young (23).

As these examples show, access is not among the varied and complex reasons for unmet need. People's fears about methods combined with traditional medical beliefs and a pattern of gender relations contribute to a high risk of unintended pregnancy

India

As mentioned above, the recent round of DHS surveys, including the National Family Health Survey in India, contain questions on reasons for non-use of methods. Table 3 shows some of that data for Uttar Pradesh (Devi, et al, 1996) -- data concerning women with unmet need who do not intend to use family planning . The differences between women who want to limit and those who want to space are striking: while slightly more than half of the limiters say they do not intend to use in the future, almost two-thirds of the spacers say they do not intend to use, mainly because they want more children. Apparently they do not perceive of family planning as a way to space births. At the same time, more of the limiters site other reasons that inhibit them from using family planning -- fear, opposition, lack of knowledge and health-related reasons. Unfortunately the study does not include data on why those who say they intend to use were not using at the time of the survey. This is an important oversight because intentions are not a perfect match with future behavior especially in low prevalence situations (Curtis and Westoff, 1996; Stover and Heaton, 1995).

TABLE 3: AMONG WOMEN WITH UNMET NEED, REASONS FOR NOT INTENDING TO USE FAMILY PLANNING IN THE FUTURE IN UTTAR PRADESH

UNMET NEED STATUS	PERCENT WHO DO NOT INTEND TO USE	TOTAL	WANTS MORE CHILD-REN	FEAR OF STERILI-ZATION	OPPOSED TO FAMILY PLANNING	SUPPLY RELATED PROB-LEMS	LACK OF KNOW-LEDGE	RELIGIOUS OPPOSI-TION	HEALTH DOES NOT PERMIT	OTHER
LIMITING	54	100	20	13	13	13	15	11	9	7
SPACING	74	100	84	1	3	3	5	3	0	4

Source: India National Family Health Survey, 1992-93.

When the team in India directly asked why women with unmet need were not using any method of family planning, their answers were not radically different from those presented in Table 3 . Women gave the following set of reasons:

1. Low motivation
   - Did not feel like using
   - Did not want the "unnecessary headache" (i.e. risk of side effects and/or inconvenience)
   - Enough people in the family to look after children, so sees no problem if another baby is born
   - Would prefer to take the risk of pregnancy and go for abortion if pregnancy occurred

2. Gender-related reasons
   - Husband does not allow use because he thinks all family planning methods are harmful

3. Religious reasons
   - Operation forbidden by religion
   - Have faith in God that won't get pregnant

4. No perceived need
   - Periods are rare or irregular
   - Intercourse infrequent

5. Poor knowledge of family planning or poor access to services
   - Not available; will use if someone provides
   - Not advised to use by anyone
   - Does not know enough, has nobody to consult

Among this set of reasons, low motivation that is most intriguing (and one of the key issues being studied in the follow-up survey currently in the field). If people's desire to avoid childbearing is weak, they may choose the known risks of childbearing over the unknown risks and perceived hassles of using a method of family planning. We want to find out if

low motivation is a reflection of a large family norm or a symptom of the powerlessness of women to act on their choices.

Analysis of the interview data also highlighted a series of indirect, contextual reasons for unmet need, many of which create barriers that provide greater challenges to policy and program planners:

1. Ideal Family Size: The ideal, for the most part, places great emphasis on bearing sons . Most of those interviewed stressed that it was important to have at least two sons, but only one daughter at most. The researchers believe there has been a change in attitude; people used to say they wanted at least two boys and would accept as many girls as would come in the process of getting those two boys. Now they limit the number of girls to one.

2. Attitudes toward Family Planning Methods. Rumors abound and affect people's attitudes toward family planning.

- Female Sterilization
  "I don't want to go for an operation. There are many diseases due to operation and that is why I don't want to get myself operated. . . . My younger sister in law's sister started suffering from gastric problems and some other problems after she got herself operated. She has become a patient after the operation." Female/Sitapur
- Male Sterilization
  "A man cannot get operated. . .Man has to perform numerous tasks. . .he has to work, he has to run, pick up heavy things…. I may get weak if I go for operation.... My wife will be operated …" Male/Agra
- Condom
  "Nirodh may make my husband weak and moreover it bursts . . ."
  Female/Sitapur
- The IUD
  "I started having excessive bleeding [from an IUD]. . . my sister in law took me to the doctor. . .I had to take five injections before the bleeding stopped."
  Female/Sitapur
- The Pill
  "And the tablet Mala D is there. … Once my bhabhi [sister-in-law] had taken Mala D then she was so weak that glucose was given to her so that we have fear and don't take these. If Mala D is taken then ¼ kg milk is required daily in the morning and evening and in addition to this apple and other dry fruits are required. We cannot afford all this and so don't use these tablets."
  Female/Sitapur

3. Poor Knowledge about Reproductive Matters
   - Women and menarche: women arrive with little knowledge about their bodies and are often terrified when they first have their periods

- Women and Sex: women arrive at marriage with little knowledge about sex
  "When I was married then I knew nothing how the sex is done and what happens in it ...I was very scared. . . I did not eat for three for days." Female/Sitapur
- Men and Sex: men arrive at marriage somewhat better informed, having learned about sex from their married friends.
  "I was aware of this which I had learned from my friends, from my married friends. I had experience before marriage. . . She was from this village . This was two years before my marriage. I had thought that I would marry her, but my family members were not ready to let me marry her." Male/Agra
- Family Planning: many of those interviewed, men and women, had little knowledge about family planning methods, how they worked or where to obtain them

4. Limited Decisionmaking Role for Women: throughout their lives, women take few decisions -- how long to stay in school, who and when to marry, when to have sex, what work to perform, much less when and how many children to have

5. Sexual Violence: For many women their wedding night was a violent introduction to sex; and sex often continues to be coercive throughout their lives -- either direct beatings if they deny sex to their husbands or a fear of beatings.

The last three reasons present grave challenges for how to define and address unmet need because they get at the heart of the difficult context of women's lives in Uttar Pradesh. Women have so little knowledge about their bodies and so little autonomy, even over the most intimate aspects of their lives, as to make the concept of unmet need for family planning almost meaningless. Even if they knew how to make choices, which they do not, they have little chance of effecting those choices. The follow-up survey is going to examine further the issues of decisionmaking/autonomy and violence, to try and put better parameters on these issues.

Zambia

A DHS analysis of the reasons why women with unmet need do not intend to use in the future is also available for Zambia, presented in Table 4. While the percentages of spacers and limiters who do not intend to use are similar, their reasons are quite different. A significant proportion of the spacers are ambivalent, while 40 percent of the limiters say they are not exposed to the risk of pregnancy. Again we do not have information on why those who said they intend to use were not using at the time of the survey.

TABLE 4: AMONG WOMEN WITH UNMET NEED IN ZAMBIA, REASONS FOR NOT INTENDING TO USE FAMILY PLANNING IN THE FUTURE

UNMET NEED STATUS	PERCENT WHO DO NOT INTEND TO USE	TOTAL	AMBIV-ALENT	UNIN-FORMED	OPPOSED	UNAVAIL-ABLE	SIDE EFFECTS	NOT EXPOSED	OTHER. DON'T KNOW
spacers	32.1	100	29.4	19.1	15.6	5.5	8.9	14.4	7.1
limiters	38.1	100	2.3	13.6	22.6	6.5	6.2	40.2	8.5

Source: Zambia Demographic and Health Survey, 1992 in Westoff and Bankole, 1994

Our very preliminary assessment of the reasons for unmet need also highlights a significant the ambivalence toward future childbearing, and raises one new and very important point:

1. Family Size Norms. People in Zambia like large families; for men in particular having a large number of off- spring is a sign of their manhood. A large extended family is the network on which people depend. But times are tough in Zambia; people are faced with severe economic constraints that, in the short run, make it difficult to support children. The contrast between a large family ideal and economic constraints leads to ambivalence about family planning.

2. Dissatisfaction with Quality of Care. Most of the women interviewed in Lusaka had used family planning at some point in the past. They could get access to a method the first time, although they were not given a choice, nor were the potential side effects explained by clinic staff. Furthermore, if they were dissatisfied with the method, follow-up support was negligible. They felt their side-effects were not taken seriously. This perception of low quality care led women to quit use altogether, to use folk methods, or to obtain supplies through irregular channels (for example, buying expired pills from street vendors).

3. Fear of Side Effects. Some are misinformation or exaggerated. But some derive from experience or hearing about other women's actual side effects, especially the symptoms of hypertension.

PROGRAM AND RESEARCH IMPLICATIONS

The causes of unmet need identified in ICRW's research program point to several program areas that would help women avoid unintended pregnancies.

1. Work to reduce the misinformation and rumors. In all three studies, people had misinformation about how family planning methods work and what the side effects are. Even when their knowledge about side effects was essentially correct, they often had exaggerated fears about the implications of those side effects. People obviously need high quality information from trusted sources (not necessarily the TV and radio) about the attributes, positive and negative, of each family planning method, and how to

choose an appropriate method for their own particular circumstances. This information must be provided in the context of, or without belittling, people's own understanding of how the body works, otherwise they will not accept it.

2. Stress quality care, so that women get appropriate methods, feel their concerns are taken seriously, and perceive that services are being offered to help them improve the quality of their lives. For example, in Guatemala the research team was assisted by a group of health volunteers called "reproinsas" who provide support for women in a holistic way, not just as "bodies" that show up at a family planning clinic. In Zambia, appropriate messages might stress that family planning helps couples have children when they feel they can afford them, as a quality of life issue.

3. Develop programs that help people learn about and make appropriate choices concerning their reproductive lives -- starting at the beginning with education about puberty and sex, to strategies for life planning, to ways to deal with violence and ways to communicate with partners, etc. One of the key issues that came out in each of the country studies is that people feel ambivalent about family planning and its role in their lives. Programs to help people understand this ambivalence and deal with it are needed. This is a very general recommendation, and must be tailored to each country's circumstances. In Uttar Pradesh it might be crucially important to begin with men, since women's lives are so circumscribed that it will be difficult to develop broad-based programs targeted to them. In Guatemala, violence is a major issue that needs to be addressed. In Zambia, the AIDS pandemic adds another dimension and suggests a focus on sexual behavior.

The studies presented here also highlight several issues about the definition itself and how to measure it:

1. Women at moderate risk of unintended pregnancy should not be excluded from the definition. These studies suggest that shifting from a focus on use or non-use of family planning to a focus on the need to avoid unintended pregnancies might make the concept more relevant to women's self-defined needs.

2. The definition should also be expanded to reflect the heterogeneity in the unmet need group beyond spacers and limiters. Past experience with family planning, intention to contracept in the future, and different degrees of motivation (for example how "upset" a woman would be if she became pregnant tomorrow) are all possible ways to categorize women with unmet need.

3. The causes of unmet need are many and varied. Most women have more than one reason for not choosing an effective way to avoid unintended pregnancies. The analysis of unmet need should reflect these multiple causes by not restricting women to one answer concerning why they are not using, and not restricting the analysis only to women who say they have no intention of using in the future.

Finally these results suggest that there maybe no universal definition of unmet need, if it is to be an effective guide to in-country program design. The combination of qualitative and quantitative approaches used by these research teams could be used as part of a process to tailor the concept of unmet need to individual country circumstances:

1. start with the (newly revised) international (DHS) definition;
2. choose from list of alternative DHS questions (regional paradigms) to make adaptations to a particular country's situation;
3. conduct a series of in-depth interviews to see how women themselves perceive their need for family planning services (their motivation) and the socio-cultural, economic and service-related barriers they face accessing services;
4. develop a country-specific definition to guide programs.

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FIGURE 1:
CONTINUUM OF RISK OF UNINTENDED PREGNANCY
AMONG SEXUALLY ACTIVE WOMEN
(WOMEN WHO SAY THEY WOULD PREFER TO AVOID A PREGNANCY)

			Should be included in expanded definition of unmet need			*Currently included in DHS definition of unmet need*		
Very low risk			**Moderate risk**			**High risk**		**Very high risk**
• users of permanent methods	• users of modern spacing methods (correct use)	• users of traditional methods (correct use)	• users (or their partners) who are dissatisfied with the method	• women (or their partners) who are using effective methods incorrectly	• women (or their partners) who are using highly ineffective methods	• women who are currently not using but have used in the past and say they intend to use in the future	• women are not using but who have used and don't know if they will in the future • women who have never used but say they intend to in the future	• women who have never used any method and say they do not intend to
• *Need continuing reproduc-tive health services*	• *Need reproductive health services including regular supply of contraceptives, information and support*		• *Need higher quality reproductive health services: especially better counseling up front, better management of side effects* • *Need research into causes of dissatisfaction and method choice beyond service-delivery factors*			• *Causes of non-use need to be studied and programs developed to best address those causes, which are not, in many cases, service-delivery related* • *Better post-partum programs*		